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Documentation Requirements - Individual Treatment Standards

The importance of maintaining a comprehensive, detailed, and uniform clinical record and documentation system cannot be overemphasized. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, and justify the treatment.

- Establish a single record per client.
- Writing is legible so that all entries in the clinical record are clear and readable.
- All portions of the record must be legible. Use caution when using double sided forms and hole punching pages.
- Errors are to be corrected by a single line through the incorrect information with the word "error," written out. Date and initial each corrected entry. Never erase, over-write, ink out, or utilize white out to correct an error.
- Errors in electronic record are to be corrected by an amended note.
- Addenda to an entry already made must be made separately with a printed name, credentials, signature, and date. Such entries are to be labeled "addendum".
- Use black ink pen or black type only. Do not use water base (felt) pens, pencils, or colored print when documenting in the clinical record.
- Draw a diagonal line through all blank portions of the document.
- Use commonly used abbreviations.
- Use behavioral descriptions to document a client's progress.
    - Imprecise: Appears depressed.
    - Precise: Crying, poor eye contact, states she is not sleeping because she is worried about her illness.
- Ensuring no duplication of service is the responsibility of all service providers. All providers share the responsibility to coordinate services and document service needs.
- A "Late Entry" is any documentation that is done on a calendar day other than the date the service was provided. When documenting a "Late Entry" note, enter the Date of Service that the service was provided, not the date the note is being written. When documenting the information of the service provided, the phrase "Late entry for (date service was provided)" should appear in the body of the note, preferably at the beginning of the note. After completion, the note should be signed and dated on the date that it is being written, not the date the service was provided, and should be filed in the medical record chronologically to when it was written, not filed by the date the service was provided. You may wish to insert a note referring to the late entry at the point it would have been included if written at the correct time.
- The medical record may be organized with the most recent entry on top (descending order) or in ascending order. However, when the record is closed, the record should read like a book, with the newest information at the end.
- Medical record retention is outlined in the provider contract to be a period of no less than (10) ten years.

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Treatment Record Requirements

General documentation requirements are provided as follows and should be applied to all CFWB client records regardless of funding source. The following information is required to be included in the client's medical record. Documentation supports the claims information submitted to Optum for provider reimbursement.

- Informed Consent/Agreement for Services/Telehealth informed consent
- The client's name or identification number on each page of the record
- The client's address; employment status; home and work telephone numbers, including emergency contacts; marital or legal status; and guardianship status
- Releases of Information
- Behavioral health intake assessment
- CFWB initial treatment plan
- Progress notes
- Documentation of continuity and coordination of care activities between the primary clinician and other behavioral health or medical clinicians, referring agency, or other professionals involved in the client's case. If the client refuses to allow such communication, this must be documented; the client's reason for refusal should also be noted.
- CFWB treatment plan update reports.
- Discharge documentation to include CFWB discharge summary.

Behavioral Health Intake Assessment

- The following elements must be contained in the assessment document:
  - Date of assessment
  - Identifying information capturing client's age, date of birth, and ethnicity
  - Source of information
- Assessments should use domains as identified below:
  - **Domain 1:** Presenting problem/needs: Current and history of presenting problem, current mental status exam, impairments in functioning
  - **Domain 2**: Trauma: Trauma exposure, reactions, screening, system involvement
  - **Domain 3:** Behavioral health history: Mental health history, substance use/abuse, previous services. For children and adolescents, prenatal and perinatal events and complete developmental history must be included
  - **Domain 4:** Medical history and medications: Physical health conditions, medication, developmental history
  - **Domain 5**: Psychosocial factors: Family, social and life circumstances, cultural considerations
  - **Domain 6:** Strength, risk, and protective factors: Client and family strengths, risk factors and behaviors, safety planning
  - **Domain 7:** Clinical summary, Treatment recommendations, Level of Care Determination: Clinical impression, summary of clinical symptoms and functional impairments, diagnostic impression, and treatment recommendation
- Clinical conclusion, which includes plan, recommendations, need for further evaluations, and/or referrals.
- DSM diagnosis/ ICD-10 code with dual diagnosis subsections (including diagnostic code number), including diagnostic uncertainty (rule-outs, provisional or unspecified).

Progress Notes

Progress notes must be written for each service billed. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. The progress note should provide an accurate description of the treatment provided, and plan for future care.

An **individual psychotherapy** note must outline:

- The type of service rendered.
- Date services were provided.
- Service delivery type; if service is being rendered via telehealth, the required components are documented.
- Narrative describing how the service addressed the CFWB referral needs.
- Amount of time spent face-to-face with client.
- Specify symptoms and problems that were the focus of clinical attention.
- Relevant clinical decisions, evidence informed interventions that are consistent with the treatment plan, identification of progress on established goals.
- Documented dates for follow-up visits.
- Next steps: Referrals, follow up date or timeframe.
- Signature of the provider rendering the services (or electronic equivalent), the provider's professional degree and licensure.

A **conjoint with child and conjoint without child session** note must also identify all those present and their contribution and response to interventions.